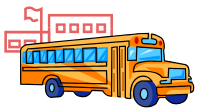

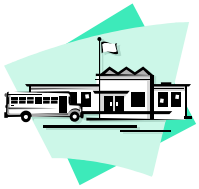

School-Based Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

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My Medicaid Provider ID Number:

IEP, even though the services may be provided to non-Medicaid children for free. However, if a child is covered by both Medicaid and private insurance, the private insurance must be billed prior to Medicaid. Exception to billing other insurance: BC/BS of Montana and CHIP.

Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

Client qualifications

To qualify for Medicaid school-based services, the client must be a Medicaid client and meet all the following criteria:

- Be Medicaid eligible on the date of service
- Be between the ages 3 and 20
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA)
- Have Medicaid reimbursable services referenced in his or her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
- In the case of CSCT services, the client must have an SED diagnosis and services may or may not be included in the client's IEP.

School qualifications

Only public school districts, full-service education cooperatives and joint boards of trustees may enroll in the Montana Medicaid school-based services program. To qualify, the district, cooperative or joint board must receive special education funding from the state's Office of Public Instruction general fund for public education. School districts include elementary, high school and K-12 districts that provide public educational services. Full-service education cooperatives and joint boards include those cooperatives eligible to receive direct state aid payments from the Superintendent of Public Instruction for special education services.

Cooperatives, joint boards, and non-public schools that do not receive state general funds for special education can not participate in the Medicaid program as a school-based provider.

Schools that employ medical service providers

- Schools who employ all or most of their medical service providers for whom the school submits bills can be enrolled with a single provider number for all services.

- Schools may use this single provider number to bill for any Medicaid covered service provided by a licensed provider.
- Schools that wish to have separate provider numbers for each provider type (e.g., speech therapists, occupational therapists, and physical therapists) can request separate provider numbers from Provider Enrollment (see *Key Contacts*).

Schools that contract with external medical service providers

- Schools that contract with all or most of their medical service providers for whom the school submits bills cannot be enrolled with a single provider number.
- Schools that contract with all or most of their providers must have the provider of service bill for each service they provide with their own individual Medicaid provider number.
- Providers and schools can arrange with the Department for payments to be made to the school. If payments are assigned to the school, the school will also have the responsibility to collect third party liability payments on behalf of the service providers.

For more information on enrollment, visit the Provider Information website or contact Provider Enrollment (see *Key Contacts*).

Physician order/referral

Medicaid does not require physician orders or referrals for health-related services that are documented in the client's IEP. The exception is private duty nursing services, which require both a written order and PASSPORT approval. Other health-related services can be authorized by a licensed school practitioner meeting the State of Montana provider requirements to secure health-related services under an IEP. For instructions on getting PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual. See the table of authorization requirements later in this chapter.

Documentation requirements

School-based services providers must maintain appropriate records. All case records must be current and available upon request. Records can be stored in any readily accessible format and location, and must be kept for six years and three months from the date of service. For more information on record keeping requirements, see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual. Medical documentation must include the following:

- Keep legible records!
- Date of service and the child's name
- The service(s) provided during the course of each treatment and how the child responded.
- Except for CSCT, the services for which the school is billing Medicaid must be written into the child's IEP.

- If the service is based on time units, (i.e. 15 minutes per unit), the provider of service should indicate begin and end times or the amount of time spent for each service. A service must take at least eight minutes to bill one unit of service if the procedure has "per 15-minutes" in its description.
- Providers must sign and date each record documented on the day the medical service was rendered. Provider initials on daily records are acceptable providing their signature is included in other medical documentation within the child's record.
- Documentation must, at least quarterly, include notes on client progress towards their goals.
- The service provider must keep sufficient documentation to support the procedure(s) billed to Medicaid. If a service is not documented, it did not happen.
- Documentation must not be created retroactively. Providers are responsible for maintaining records at the time of service.
- CSCT services are not required to be included in the IEP because often clients that require these services do not fit the special education requirements. The clinical assessment must document the medical necessity and the clinical treatment plan must demonstrate how the CSCT services will address the medical necessity. In addition to the above requirements, CSCT documentation must also include:
    - Where services were provided;
    - Result of service and how service relates to the treatment plan and goals;
    - Progress notes for each individual therapy and other direct service;
    - Monthly overall progress notes;
    - Individual outcomes compared to baseline measures and established benchmarks.

The Montana Medicaid School-Based Services Program is subject to both state and federal audits. As the Medicaid provider, the school certifies that the services being claimed for Medicaid reimbursement are medically necessary and furnished under the provider's direction. Both fiscal and clinical compliance are monitored. In the event of adverse findings, the district/cooperative (not the mental health provider) will be held responsible for any paybacks to Medicaid. If school districts have included a program area for CSCT in their accounting system, then the district can book revenue received from third party insurers or parents that paid privately for CSCT services, providing audit documentation (see the *Comprehensive School and Community Treatment* section in this chapter). To assist in document retention for audit purposes, see the *Audit Preparation Checklist* in *Appendix A: Forms*.

Non-covered services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Medicaid.

- A provider's time while attending client care meetings, Individual Educational Plan (IEP) meetings, individual treatment plan meetings, or client-related meetings with other medical professionals or family members
- A provider's time while completing IEP related paperwork or reports, writing the CSCT individualized treatment plans or documenting medical services provided
- CSCT services provided without an individualized treatment plan for this service
- Services considered experimental or investigational
- Services that are educational or instructional in nature
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment.

Use the current fee schedule for your provider type to verify coverage for specific services.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's school-based services fee schedule. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific school-based services.

Assessment to initiate an IEP

Medicaid covers medical evaluations (assessments) to develop an IEP as long as an IEP is subsequently established and health-related needs are identified.

The CSCT Program must follow *free care rules* (see *Definitions)*.

Comprehensive School and Community Treatment (CSCT)

Comprehensive School and Community Treatment (CSCT) is a very intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community. CSCT provides a comprehensive, planned course of outpatient treatment provided primarily in the school to a child with a serious emotional disturbance (SED). These services are provided through a program operated by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center. CSCT services include, among other services, individual, group and family therapy and behaviorial interventions.

lor, or a DPHHS approved in-training mental health professional. The minimum staffing requirement for a program is one team with the capacity to provide up to 720 units per calendar month to children with SED. Part-time staff may be utilized but the billing units must be reduced proportionately.

- *Caseload* refers to the total number of units the CSCT program team may provide in a calendar month. Ideally the staff and CSCT clients should be all contained in one school. It is acceptable, however, for a CSCT program team to provide up to 720 units to be spread across no more than two schools located in close proximity of one another. Coverage by a CSCT team of more than two school campuses is not acceptable.
- The expectation is that the full-time CSCT staff will be available throughout each day to meet the needs of the CSCT clients. It is not generally appropriate, therefore, for the licensed or in-training mental health professional CSCT worker to have an outpatient caseload in addition to CSCT duties. The only exception is youth transitioning out of CSCT who need some therapeutic support.
- The use of an "in-training mental health professional" in a CSCT program is allowed on an infrequent and exceptional basis. It is recognized that recruitment of licensed professionals may be difficult in some parts of the state. Approval for such an arrangement must be obtained from the Children's Mental Health Bureau in writing. In its request to use an in-training mental health professional the CSCT program must document the following:
  - The program has advertised for a licensed professional unsuccessfully in newspapers and through Job Service for at least three weeks. The program must have offered a salary that is competitive for the community in which the program is located. The Department will not approve the use of an in-training mental health professional unless a salary of at least state pay plan grade 15, entry level plus benefits including health insurance, has been offered during the unsuccessful recruitment.
  - The in-training mental health professional has completed all academic work required for the license and has begun the post-degree supervised experience required for licensure.
  - A licensed professional has entered into a written agreement to provide supervision of the post degree experience required for licensure.
  - A licensure examination date (or at least an approximate date) has been selected.
  - The in-training mental health professional may serve in lieu of a licensed CSCT staff for no more than 2 years.

    - The in-training mental health professional has had relevant prior experience serving SED children.
    - The CSCT program offers, at a minimum, face-to-face supervision by a licensed professional that meets the appropriate discipline licensing standard, at the CSCT site.
- CSCT services must also be available for non-Medicaid clients who meet the CSCT program requirements. In addition to providing these services, districts/cooperatives must also request payment for these services. Services may be billed based on a sliding fee schedule to non-Medicaid children. Schools may contract with their CSCT provider to bill Medicaid, private-pay patients and insurance carriers.
- CSCT services not specified in the IEP must be made available and billed to **all** children who receive services.
- Providers may not bill Medicaid for any CSCT services that are generally offered to all clients without charge.
- CSCT services do not require PASSPORT approval or inclusion in the child's IEP.
- CSCT services must be provided according to an individualized treatment plan. The treatment plan must be reviewed and approved by a licensed professional who is a CSCT staff member.

Billable Services

- Face to face service
    - Individual
    - Family
    - Group
    - Behavioral interventions

Services restricted

Medicaid does not cover the following services under the CSCT program:

- Observation and monitoring/supervision
- Non-face to face service
- Time in meetings
- More than 720 units of service per CSCT team per calendar month
- Prior authorization is required for outpatient therapy services provided concurrently or outside the CSCT program.
- Educational assistance or assisting with homework
- Watching movies

Therapy services

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's Medicaid provider number (see the *Billing Procedures* chapter in this manual).

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client Help Lines are available to answer almost any PASSPORT or general Medicaid question.

Prior Authorization

Some services require prior authorization (PA) before they are provided, such as private duty nursing services. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

PA Criteria for Specific Services

Service	PA Contact	Requirements
• **Private Duty Nursing Services**	Medicaid Utilization Review Department Mountain Pacific Quality Health Foundation P.O. Box 6488 Helena, MT 59604-6488 Questions regarding this process can be answered by calling: **Helena:** (406) 443-4020 ext. 150 **Outside Helena:** (800) 262-1545 ext. 150 **Fax:** (406) 443-4585	The number of units approved for private duty nursing services is based on the time required to perform a skilled nursing task. • A prior authorization request must be sent to the Medicaid Utilization Review Department's peer review organization accompanied by a physician or mid-level practitioner order/referral for private duty nursing. • Prior authorization must be requested at the time of initial submission of the nursing plan of care and any time the plan of care is amended. • Providers of private duty nursing services are responsible for requesting prior authorization and obtaining renewal of prior authorization. • Requests for prior authorization must be obtained for the regular school year (August/September through May/June). Services provided during the summer months must be prior authorized in addition to the services provided during the regular school year. Remember, schools are responsible for obtaining the physician orders and PASSPORT approval for new or amended requests for prior authorization. Prior authorization requests must be submitted to Mountain Pacific Quality Health Foundation ***in advance*** of providing the service. • Providers are required to send in prior authorization requests two weeks prior to the current prior authorization request end date for recipients receiving ongoing services. • Total number for units of service paid on claims must not exceed those authorized by the Medicaid Utilization Review Department. Payment will not be made for units of service in excess of those approved. • No retrospective prior authorization reviews will be allowed. • To request prior approval submit a completed *Request for Private Duty Nursing Services* form located in *Appendix A: Forms* of this manual and on the Provider Information website under *Forms*. Send completed requests to the contact shown in the second column.
• **Outpatient mental health therapy provided outside or concurrently with CSCT**	First Health Phone: (800) 770-3084 FAX: (800) 639-8982 Address: 4300 Cox Road Glen Allen, VA 23060	Client Name and ID MHC Provider Number Procedure code(s) Diagnosis (es)

Other Programs

The Children's Mental Health Services Plan (CMHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*).

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*).
When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.

Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

School-Based Services Codes

Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15 minute unit
School Psychologist / Mental Health Services		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96101	Per hour
CSCT Program		
CSCT services	H0036	15 minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15 minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip
Audiology		
Audiology evaluation	92557	Per visit
Tympanometry	92567	Per visit
Evoked otoacoustic emission; limited	92587	Per visit

Using modifiers

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers may be used in schools:

- Modifier "52" is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.